

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 5-26-04.

The requestor submitted an updated table showing that the office visits on 12-12-03, 12-15-03, and 12-17-03 were paid by the Carrier. These items are no longer in dispute.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The Levels II and III office visits, aquatic therapy, therapeutic exercises, manual therapy technique, neuromuscular re-education, electrical stimulation, therapeutic procedure and computer data analysis from 8-1-03 through 1-20-04 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 7-14-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Per Rule 134.202(d), reimbursement shall be the **least** of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge). For the following services, the requestor did not bill the correct MAR

amount. Reimbursement shall be according to the Medicare Fee Guidelines effective 8-3-03.

CPT code 97113 for dates of service 11-10-03 (4 units) and 12-8-03 (2 units) was denied by the Carrier with an F – “Reimbursement has been calculated according to the state fee schedule guidelines or relative and actual charge data amounts.” For date of service 11-10-03 the EOB revealed that the carrier had given an allowance to the requestor. However, the requestor submitted an updated Table of Disputed Items on 12-28-04 showing that no additional reimbursement had been made. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of \$203.06. (\$126.60 for DOS 11-10-03, + \$76.46 for DOS 12-8-03)**

CPT code 97112 for dates of service 11-10-03, 11-20-03, 11-26-03, 12-5-03, 12-8-03, 12-10-03, 12-17-03, 1-2-04 and 1-26-04 was denied by the Carrier with an F with the explanation, “Reimbursement has been calculated according to the state fee schedule guidelines or relative and actual charge data amounts.” For some dates of service the EOB revealed that the carrier had given an allowance. However, the requestor submitted an updated Table of Disputed Items on 12-28-04 showing that no additional reimbursement had been made. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of \$330.33. (\$36.69 x 7 + \$36.75 x 2)**

CPT code 97140 for dates of service 11-10-03, 11-20-03, 11-26-03, 12-5-03, 12-8-03, 12-10-03, 12-17-03, 1-2-04 and 1-26-04 was denied by the Carrier with an F with the explanation, “Reimbursement has been calculated according to the state fee schedule guidelines or relative and actual charge data amounts.” For some dates of service the EOB revealed that the carrier had given an allowance. However, the requestor submitted an updated Table of Disputed Items on 12-28-04 showing that no additional reimbursement had been made. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of \$305.12. (\$33.90 x 7 + \$33.91 x 2)**

CPT code 97110 for dates of service 11-10-03, 11-20-03, 11-26-03, 12-5-03, 12-8-03, 12-10-03, 12-17-03, 1-2-04 and 1-26-04 was denied by the Carrier with an F with the explanation, “Reimbursement has been calculated according to the state fee schedule guidelines or relative and actual charge data amounts.” Recent review of disputes involving CPT Code 97110 by the Medical Dispute

Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-

one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Reimbursement not recommended.**

CPT code 99212 for dates of service 11-20-03, 11-26-03, 12-5-03, 12-8-03, 12-10-03, 1-2-04 and 1-26-04 was denied by the Carrier with an F with the explanation, "Reimbursement has been calculated according to the state fee schedule guidelines or relative and actual charge data amounts." For some dates of service the EOB revealed that the carrier had given an allowance. However, the requestor submitted an updated Table of Disputed Items on 12-28-04 showing that no additional reimbursement had been made. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of \$328.11. (\$46.41 x 5 + \$48.03 x 2)**

Regarding CPT code 99212 for dates of service 9-19-03, 12-1-03, 12-4-03: Neither the carrier nor the requestor provided EOB's for date of service. However, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with 133.307 (e)(2)(B). **Recommend reimbursement of \$139.23. (\$46.41x 3)**

CPT code 97032 for dates of service 11-20-03, 11-26-03, 12-5-03, 12-10-03, 12-17-03, 1-2-04 and 1-26-04 was denied by the Carrier with an F with the explanation, "Reimbursement has been calculated according to the state fee schedule guidelines or relative and actual charge data amounts." For some dates of service the EOB revealed that the carrier had given an allowance. However, the requestor submitted an updated Table of Disputed Items on 12-28-04 showing that no additional reimbursement had been made. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of \$140.28. (\$20.04 x 7)**

This Finding and Decision is hereby issued this 29<sup>th</sup> day of December , 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 8-1-03 through 1-26-04 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 29<sup>th</sup> day of December , 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

Enclosure: IRO decision

November 8, 2004

Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

**REVISED REPORT**  
**Corrected services in dispute – addition of Therapeutic Procedure**

Re: Medical Dispute Resolution  
MDR #: M5-04-3236-01  
TWCC#:  
Injured Employee:  
DOI:  
SS#:  
IRO Certificate No.:

Dear

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

## **REVIEWER'S REPORT**

### **Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: letter of medical necessity, office notes, physical therapy notes, FCE, nerve conduction study, operative and radiology reports.

Information provided by Respondent: correspondence and designated doctor exams.

Information provided by Pain Specialists (2): office notes and radiology reports.

Information provided by a second Treating Chiropractor: office notes, radiology reports and various evaluations and tests.

### **Clinical History:**

The patient sustained a lumbar injury on \_\_\_. After exhausted diagnostic and conservative measures, he eventually underwent laminectomy on 5/20/03. No treatment records were submitted for the time period between 5/20/03 and the beginning of submitted therapy notes of 7/7/03. From 7/7/03 through 1/20/04 the patient was afforded treatment consisting of aquatic therapy, varying passive physical modalities for pain management and restorative effects and was progressed into land-based therapeutic exercises as allowed.

### **Disputed Services:**

Levels II & III office visits, aquatic therapy therapeutic exercises, manual therapy technique, neuromuscular re-education, electrical stimulation, therapeutic procedure, and computer data analysis from 08/01/03 through 01/20/04.

### **Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of

the opinion that the treatment and services in dispute as stated above were medically necessary in this case.

**Rationale:**

The level II and III office visits are necessary in order to evaluate, consult, counsel, and manage a patient who is in this type of pain for this long. Post-surgical reconditioning is a time-consuming endeavor. The extended treatment time is afforded by the National Guidelines for Unremitting Low Back Pain as adopted from the North American Spine Society, and the primary therapies of (i) aquatic exercises progressing to land-based; (ii) therapeutic exercises and therapeutic procedures are also appropriate. The manual therapy techniques and electrical stimulation are necessary to loosen scar tissue, relieve this patient's acute post-exertional exacerbations, encourage the patient, and maintain good patient compliance.

The neuromuscular re-education when mentioned in conjunction with Swiss gym ball exercises is necessary to recondition the fast twitch muscle fibers in the spine, which coordinate and balance the force of the slow twitch muscle fibers. The computer data analysis is medically necessary to attempt to objectively track the patient's progress so appropriate decision making and goal setting can be intelligently performed. According to the records submitted, post-surgical therapy began on 7/7/03. The first post-surgical FCE was performed on 10/7/03 and indicated this patient was far from being ready to return to work; therapy continued. The second FCE was performed on 12/22/03 and indicated that this patient had not progressed. I am assuming the current treatment regimen ended on 1/20/04 after the patient demonstrated that he had in fact reached a plateau and was not going to significantly improve in a timely manner. The records submitted by all parties ended on 1/20/04.